Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

LOUIS D BERNSTEIN, MD
PO BOX 741865
DALLAS, TX 75374

Respondent Name

ACE AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 15

MFDR Tracking Number

M4-11-1381-1

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER IS REQUESTED TO PAY DD EXAMS"

Amount in Dispute: $650.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "Per peer review dated 9-3-10…no further treatment is reasonable or necessary"

Response Submitted by: Specialty Risk Services, 1851 East 1st St. #200, Santa Ana, CA 92705

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 1, 2010	99456-WP-W5	$650.00	$650.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.204 sets out Medical Fee Guidelines for workers' compensation specific services effective March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated October 29, 2010
   - 16 – Claim/service lacks information which is needed for adjudication.

Explanation of benefits dated November 26, 2010

- 18 – Duplicate claim/service.
- 214 – Workers Compensation claims adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact the SRS Claims Examiner regarding these charges.

Explanation of benefits dated January 18, 2011

- Services denied. Please contact the SRS Claims Examiner regarding these charges.

Issues

1. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
2. Is the requestor entitled to reimbursement?

Findings

1. Texas Labor Code §408.0041 states in (h)(1):
   (h) The insurance carrier shall pay for:
   (1) an examination required under Subsection (a) or (f).

   Texas Labor Code §408.0041 states in part (a)(1)(2):
   (a) At the request of an insurance carrier or an employee, or on the commissioner's own order, the commissioner may order a medical examination to resolve any question about:
   (1) the impairment caused by the compensable injury;
   (2) the attainment of maximum medical improvement;

   The requestor rendered the DD exam as ordered by the Division. A peer review regarding treatment does not affect reimbursement of Division ordered evaluation service per Texas Labor Code §408.0041. The respondent's denial reason of "214 – Workers Compensation claims adjudicated as non-compensable. This Payer not liable for claim or service/treatment. Services denied. Please contact the SRS Claims Examiner regarding these charges." is not supported. Therefore requestor is entitled to reimbursement per Medical Fee Guidelines in 28 Texas Administrative Code §134.204.
2. The provider billed the amount of $650.00 for CPT code 99456-W5-WP for DD Examination for MMI/IR. Review of the documentation supports that MMI was assigned and one body area was rated. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions is reviewed. Per 28 Texas Administrative Code §134.204(j)(4)(C)(ii)(II)(a), the MAR for a 1st musculoskeletal area IR using Range of Motion (ROM) on the right ankle and great toe (lower extremities) is $300.00. The combined MAR for the MMI/IR exam is $650.00. Therefore, the requestor is entitled to reimbursement of $650.00.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $650.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $650.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	November 1, 2011 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.